

Motives and Suicide Intent Underlying Hospital Treated Deliberate Self-Harm and Their Association with Repetition

CARMEL MCAULIFFE, MPhil, ELLA ARENSMAN, PhD,
HELEN S. KEELEY, MD, MRCPsych, PAUL CORCORAN, MSc,
AND ANTHONY P. FITZGERALD, ScD

The association between motives for deliberate self-harm (DSH), level of suicide intent, and history of DSH is poorly understood. As part of the WHO/EURO Multicentre Study on Suicidal Behavior, the Suicide Intent Scale, and the Motives for Parasuicide Questionnaire were administered to 146 patients presenting with DSH in the Cork region in Ireland. DSH patients reporting high suicide intent were more motivated to escape from their problem ($M = 3.15$, $p < .001$) compared to those with low suicide intent, who were more motivated to appeal to others ($M = 1.61$, $p < .001$) and to get a temporary break from their problem ($M = 2.47$, $p < .001$). Repeaters more often reported motives aimed at escape ($M = 2.98$, $p < .01$), revenge ($M = .60$, $p < .005$), and appeal ($M = 1.43$, $p = <.05$). Self-harming patients are characterized by ambivalence and struggle with aversive thoughts and situations. Therapeutic approaches should include distress management and coping strategies.

Deliberate self-harm (DSH) among young men and women poses a significant challenge to the health system in Ireland and interna-

tionally (Corcoran, Keeley, O'Sullivan, & Perry, 2003; Schmidtke, Bille-Brahe, De Leo, & Kerkhof, 2005). An estimated 11,100 hospital presentations due to DSH were made by 8,600 individuals in Ireland in 2004 (National Parasuicide Registry, 2005). More than one-fifth of these presentations were due to repeat acts and the proportion of presentations in Ireland due to repeat acts—as in other countries—is increasing (Hawton et al., 2003; Henriques, Brown, Berk, & Beck, 2004; National Parasuicide Registry, 2004). Motives reported by individuals engaging in DSH are important in clinical risk assessment for further suicidal behavior and also in clinical decision-making about appropriate follow-up treatment (Boergers, Spirito, & Donaldson, 1998; Hawton, 2000).

Deliberate self-harm is used to describe different types of behaviors associated with varying levels of suicide intent and a wide va-

The authors are with the National Suicide Research Foundation, Cork, Ireland; HELEN S. KEELEY is also with Child and Adolescent Mental Health Services (CAMHS) North Cork, Health Service Executive, Southern Area, Mallow, Co. Cork, Ireland; ANTHONY P. FITZGERALD is also with the Department of Epidemiology & Public Health, University College Cork, Ireland.

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Address correspondence to Carmel McAuliffe, MPhil, National Suicide Research Foundation, 1 Perrott Avenue, College Road, Cork, Ireland; E-mail: carmel.nsrff@iol.ie

riety of motives. Suicide intent at the time of a self-harm episode is associated with risk of subsequent suicide (Pierce, 1981; Niméus, Traskman-Bendz, & Alsen, 1997; Harriss, Hawton, & Zahl, 2005) and patients presenting with DSH who verbalize an intention to die have been found to engage in more life-threatening episodes (Bancroft, Skrimshire, & Simkin, 1976; Hjelmeland, 1995). However, the noted ambivalence of individuals following DSH has necessitated the investigation of other motives. Usually, several motives are reported by an individual who has engaged in DSH (Hjelmeland et al., 2002), even among those who indicate a wish to die (Loughrey & Kerr, 1989; Rodham, Hawton, & Evans, 2004; Sullivan, Arensman, Keeley, Corcoran, & Perry, 2004, Sullivan, Corcoran, Arensman, & Perry, 2005, submitted).

Birtchnell and Alarcon (1971) were among the first to examine motives other than death in individuals who had engaged in DSH. The majority of patients in their sample selected at least one 'nondeath' motive. *Feeling lonely or unwanted* was the most frequently selected motive (53% of the sample). Those who had expressed a wish to die reported significantly more motives, showing evidence of ambivalence.

Intrapersonal/internal motives—to end an acute or unbearable state of mind or to escape or take action in an unbearable situation—have been the most commonly reported motives in a number of studies, starting with Bancroft and colleagues' studies of DSH patients in Oxford (1976; 1979). This finding was replicated in the WHO/EURO Multicentre Study on Suicidal Behavior, reporting on findings from 16 regions across 14 countries in Europe, which used a modified version of Bancroft's original list of motives (Chopin, Kerkhof, & Arensman, 2004). Adolescents engaging in DSH report similar motives to those of adults, such as to obtain relief, to die (Boergers et al., 1998; Rodham et al., 2004; Sullivan et al., 2004), and to escape (Boergers et al., 1998). In the study by Sullivan and colleagues (2004), all adolescents who reported a wish to die also reported at least one other *nondeath* motive, again pro-

viding evidence of considerable ambivalence.

To our knowledge only two previous studies investigated the association between motives other than death and levels of suicide intent. One was a large cross-cultural study based on interviews with patients presenting with DSH in 14 regions across 13 European countries as part of the WHO/EURO Multicentre Study on Suicidal Behavior (Hjelmeland et al., 2002). A positive correlation was found between scores on the Suicide Intent Scale (SIS) and the motive *Final Exit* (unbearable thoughts and situations, the intention to die, and the wish to make things easier for others). The other motives (*Care Seeking, Influencing Others, and Temporary Escape*) and a single item, *loss of control*, were all negatively correlated with SIS scores. The same pattern was found for men and women. They did not investigate the association between motives, suicide intent, and repetition. A second study found that the motive, *to die*, was associated with a significantly higher SIS score (Loughrey & Kerr, 1989), but they did not find any association between motives and repetition, which may be due to the relatively small sample size, as only 50 patients were interviewed.

The principal aims of the present study are to describe the motives and suicide intent reported by a nonconsecutive sample of medically referred patients presenting with DSH—comparing them separately for each gender—and to investigate the association between motives for DSH, level of suicide intent, and history of DSH, as assessed at index episode. This work was part of a larger study—the Repetition-Prediction part of the WHO/EURO Multicentre Study on Suicidal Behavior.

METHOD

Participants

The participants comprise a nonconsecutive sample of 146 medically-treated DSH patients aged between 14 and 70 years who presented to the accident and emer-

gency department of one of the three acute hospitals in Cork city, between 1995 and 1997. The liaison psychiatrist assessing self-harm in all three departments asked DSH patients for consent at the time of the psychiatric assessment before contacting the research interviewers. Patients who left the department before psychiatric assessment could not be approached and some refused, leading to a nonconsecutive sample. The participants were interviewed as part of the Repetition-Prediction section of the WHO/EURO Multicentre Study on Suicidal Behavior, using the European Parasuicide Study Interview Schedule I (EPSIS I). These interviews generally took place within 72 hours of the index act. Deliberate self-harm was defined according to the definition of parasuicide/attempted suicide devised by the WHO Working Group of the WHO/EURO Multicentre Study on Suicidal Behavior:

an act with nonfatal outcome, in which an individual deliberately initiates a nonhabitual behavior that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences (Platt et al., 1992).

This definition includes acts that are interrupted before self-harm is inflicted, for example, a person removed from a bridge before jumping off, but excludes episodes of self-harm by individuals who do not understand the meaning or the outcome of their act, for example, due to a learning disability or severe mental disorder (Bille-Brahe et al., 1994). In recent years, the term deliberate self-harm has become the preferred term in English-speaking Europe for the behavior referred to by the WHO study definition. Therefore, we use the term deliberate self-harm in this paper. On the basis of the relevant section of the EPSIS I, repeaters are defined as patients who engage in more than one act of DSH before their EPSIS I inter-

view. First everers are patients whose index episode was their only known act of DSH at the time of the EPSIS I interview.

Measures

The European Parasuicide Study Interview Schedule (EPSIS I; Kerkhof, Bernasco, Bille-Brahe, Platt, & Schmidtke, 1993) is a structured interview schedule, designed specifically for use in the WHO/EURO Repetition-Prediction study, to conduct interviews with patients presenting with DSH. EPSIS I includes a number of standardized and nonstandardized scales assessing several areas of inquiry including: suicide intent, characteristics of the index episode, mood, hopelessness, self-esteem, and life events.

Suicide intent was assessed using the Suicide Intent Scale (SIS; Beck, Schuyler, & Herman, 1974), which was developed for use specifically with people who have recently engaged in DSH, to measure the severity of the wish to die at the time of the DSH episode. It contains fifteen items, which are scored 0, 1, or 2, with a minimum score of 0 and a maximum score of 30. The first eight items examine the physical, objective circumstances of the act of self-harm, while the remaining seven items address the individual's subjective thoughts and feelings about the act itself. The SIS has good internal consistency ($\alpha = .85$; Spirito, Sterling, Donaldson, & Arrihan, 1996).

Motives underlying DSH were explored in the Motives for Parasuicide Questionnaire (MPQ; Kerkhof et al., 1993), which is based on earlier work (Birtchnell & Alarcon, 1971; Bancroft et al., 1976; Bancroft et al., 1979; Hawton, Cole, O'Grady, & Osborn, 1982) and consists of a list of 14 motives associated with the index episode (Figure 1). Participants were asked to indicate whether the motives had *no influence*, a *minor influence*, or a *major influence* on their actions. Earlier factor analysis of the MPQ (Hjelmeland et al., 1998) resulted in four factors: Revenge/manipulation ($\alpha = .80$), Intention to die ($\alpha = .62$), Seeking attention ($\alpha = .57$), and Escape ($\alpha = .55$), with eigenvalues greater

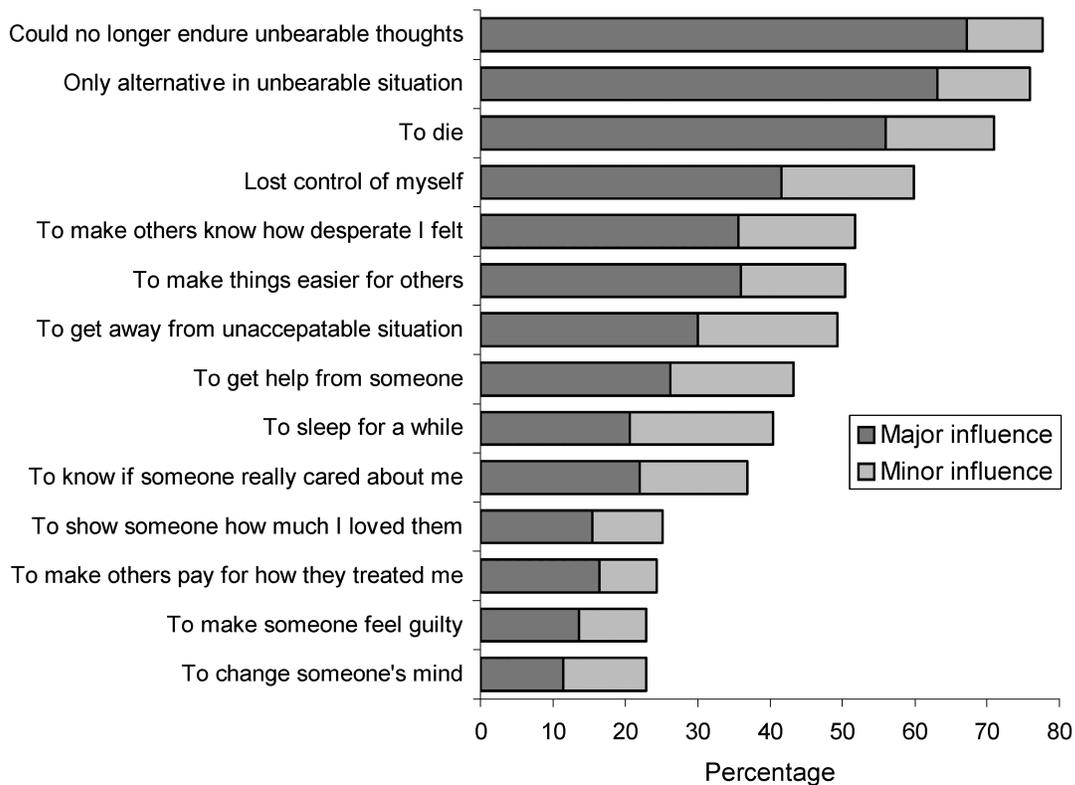


Figure 1. Influence of motives for deliberate self-harm.

than 1, which when combined accounted for 58.8% of the total variance.

Statistical Analysis

The EPSIS I sample was compared with the entire population of DSH patients who were monitored in the Cork region over the period 1995 to 1997, with respect to a range of variables using the chi-square test and Student's t-test as appropriate.

Factor analysis using varimax rotation was used to examine the internal structure of the responses to the MPQ.

To examine the relationship between suicide intent and patient characteristics, total SIS scores were divided into two categories, Low and High, by taking the median score for the study sample as the cut-off point. An independent samples t-test was also used to examine the effects of Low versus High SIS scores on mean scores on the motive factors.

Independent samples t-tests were also used to examine the effects of gender and repeater status on scores on the SIS and also on the mean scores on the motive factors. Results were confirmed using a nonparametric Mann-Whitney rank sum test.

Finally, a logistic regression was used to examine associations between scores on the motive factors and history of DSH (first ever vs. repeater) and level of suicide intent (Low vs. High). We tested for trends across ordered motive categories by entering motive scores as independent variables.

RESULTS

EPSIS I Sample Compared with the Hospital Treated Population of DSH Patients

Table 1 describes the EPSIS I sample in comparison with the population of DSH

TABLE 1
Comparison of EPSIS I Sample with Hospital-Treated Deliberate Self-Harm Population

Characteristic	EPSIS I (<i>n</i> = 146)	DSH population ¹ (<i>n</i> = 1415)
Gender (male)*	68 (47%)	649 (46%)
Age median (lower & upper quartile)	29 (21 & 39) years	27 (20 & 39) years
Marital status (never married)	94 (66%)	915 (67%)
Living situation (with family/friends)	62 (44%)	702 (52%)
Education (completed 2nd level, lower cycle)	90 (69%)	543 (64%)
Employment status (employed)	47 (34%)	325 (27%)
Method of self-harm (self-poisoning only)***	104 (71%)	1166 (84%)
Previous history of DSH at index act***	84 (62%)	409 (32%)
Presence of psychiatric disorder (ICD-10)	109 (87%)	911 (85%)
Depression (ICD-10 F30-39)**	59 (47%)	377 (35%)
Substance abuse (ICD-10 F10-19)	44 (35%)	360 (34%)
Adjustment disorder (ICD-10 F43)	24 (19%)	269 (25%)

p* < .05; *p* < .01; ****p* < .001.

¹DSH population excluding those patients in the EPSIS I sample. Percentages adjusted for missing values.

patients that presented to hospitals in Cork city over the period 1995–1997 who were not interviewed, with respect to 12 variables that relate to their demographic characteristics, index episode, and psychiatric diagnosis. The mean age of the interviewed sample was 31.81 years (*SD* = 12.40) and just under half (47%) were male. Over two-thirds (69%) had left school without obtaining a leaving certificate and only one-third (34%) were employed. Demographically, both groups were similar. The EPSIS I sample were significantly older, although the magnitude of this difference was relatively small. They were significantly less likely to have used self-poisoning alone as a method of DSH in their index act (71% vs. 84%). They were significantly more likely to have a previous history of DSH (62% vs. 32%). Almost half (47%) of those interviewed were diagnosed with a depressive disorder, which was significantly more common compared to those who were not interviewed (35%). Among those interviewed, the proportion of repeaters was similar for males (61.2%) and females (62.3%).

Motives

For the total sample the mean number of motives reported was 6.43 (*SD* = 3.23, range

1–14). All but one person selected more than one motive. The most frequently selected motives represented a desire to escape: “My thoughts were so unbearable I could not endure them any longer.” “The situation was so unbearable that I could not think of any other alternative,” and “I wanted to die” (Figure 1). In every case, over 70% of participants indicated that one of these motives had an influence on what they had done. All three motives were also most commonly selected as having a major influence on what participants did.

Factor Analysis of Responses to the MPQ

Factor analysis of the fourteen-item MPQ using varimax rotation yielded four factors, which accounted for 62.7% of the total variance. The four factors, *Interruption*, *Revenge*, *Appeal*, and *Escape* explained 29.5%, 16.1%, 9.5%, and 7.5% of the variance respectively, all with eigenvalues >1. The item loadings on the four factors, together with their factor loadings, alpha's, and eigenvalues are presented in Table 2. The range of missing values for the motive factors were: Interruption (7 individuals missing scores), Revenge (7 individuals missing scores), Appeal

TABLE 2
Factor Structure of the MPQ

Factor	N items	Items	Factor loading	Eigenvalue
Interruption $\alpha = .65$	4	1. It seemed that I lost control over myself and I do not know why I did it	.44	4.13
		2. I wanted to get away for a while from an unacceptable situation	.76	
		3. I wanted others to know how desperate I felt	.52	
		4. I wanted to sleep for a while	.72	
Revenge $\alpha = .90$	2	1. I wanted others to pay for the way they treated me	.91	2.26
		2. I wanted to make someone feel guilty	.90	
Appeal $\alpha = .74$		1. I wanted to show someone how much I loved him/her	.73	1.33
		2. I wanted to get help from someone	.45	
		3. I wanted to know if someone really cared about me	.67	
		4. I wanted to persuade someone to change his/her mind	.78	
Escape $\alpha = .62$	4	1. My thoughts were so unbearable, I could not endure them any longer	.79	1.05
		2. The situation was so unbearable that I could not think of any other alternative	.70	
		3. I wanted to die	.50	
		4. I wanted to make things easier for others	.60	

(7 individuals missing scores), and Escape (9 individuals missing scores).

Suicide Intent

The median total SIS score was 15 (range 1–28) with a mean score of 14.82 ($SD = 6.71$) and internal consistency was satisfactory (Cronbach's $\alpha = .86$). There were three missing values for the SIS.

Motives Compared by Repeater Status, Gender, and Suicide Intent Level

Repeaters selected significantly more individual motives ($M = 6.90$, $SD = 3.32$) than first everers ($M = 5.50$, $SD = 2.70$, $p = .011$) (there were 10 missing values for repeater status). There was no significant difference between males and females with regard to the number of individual motives selected ($p = .55$). Patients with Low suicide intent reported significantly more motives ($M = 7.07$,

$SD = 3.19$) than those with High suicide intent ($M = 5.72$, $SD = 3.15$, $p = .017$). Mean scores on all four motive factors were compared by repeater status and gender (Table 3). The mean scores on three of the four motive factors were significantly different when compared by repeater status. On average, repeaters scored higher on the *Revenge*, *Appeal*, and *Escape* motive factors. There were no significant gender differences on any of the motive factors. When responses to individual items on the MPQ were compared separately for men and women, no differences were found. Patients with high scores on the SIS scored significantly higher on the Escape motive factor (Table 3). Low SIS scoring patients scored significantly higher on the Interruption and Appeal factors (Table 3).

Suicide Intent Compared by Repeater Status and Gender

Mean scores on the SIS were compared by repeater status and gender (Table

TABLE 3
Comparison of Mean (Standard Deviation) SIS and Motive Scores by Repeater Status and Gender

Variable	Male (<i>n</i> = 68)	Female (<i>n</i> = 78)	First ever (<i>n</i> = 52)	Repeater (<i>n</i> = 84)	Low SIS (below 16) (<i>n</i> = 81)	High SIS (16 and over) (<i>n</i> = 62)
Interruption	1.87 (1.36)	2.13 (1.38)	2.06 (1.36)	1.94 (1.38)	2.47 (1.17)****	1.40 (1.37)
Revenge	0.46 (0.77)	0.47 (0.82)	0.21 (0.57)***	0.60 (0.85)	0.55 (0.84)	0.38 (0.73)
Appeal	1.21 (1.33)	1.31 (1.34)	0.90 (1.22)*	1.43 (1.31)	1.61 (1.34)****	0.85 (1.22)
Escape	2.73 (1.23)	2.76 (1.15)	2.39 (1.23)**	2.98 (1.11)	2.47 (1.32)****	3.15 (0.81)
SIS	15.43 (7.03)	14.29 (6.43)	14.15 (7.25)	15.60 (6.38)		

p* < .05; *p* < .01; ****p* < .005; *****p* < .001

3). There were no significant differences between repeaters and first ever or between males and females on the SIS.

Wish to Die, Level of Suicide Intent and Other Motives

Those who reported “I wanted to die” scored significantly higher on the SIS ($M = 17.44$, $SD = 5.34$) than those who did not ($M = 8.72$, $SD = 5.78$, $p < 0.0001$). All of those who reported the motive “I wanted to die” reported at least one other motive ($M = 5.73$, $SD = 3.31$) and did not differ significantly from those who did not report a wish to die ($M = 5.76$, $SD = 2.99$, $p = .96$) with regard to the number of other motives reported.

Logistic Regression

For each of the motive factor scores we examined associations with repeater/first ever status and with High vs. Low suicide intent using univariate (Table 4) and multivariate logistic regression analyses.

Univariate Analysis

There was a significant positive association between previous DSH and scores on the motive factors Escape, Revenge, and Appeal. Although subjects with high scores on the Escape motive factor also tended to have high scores on both Appeal and Interruption motive factors, high levels of suicide intent

were significantly associated with high scores on the Escape motive, but with low scores on the Appeal and Interruption motives. These results were consistent with those obtained when between group differences in average scores were examined.

Multivariate Analysis

Finally, we considered a multivariate analysis that included all the motive factors that showed significant univariate associations. Although Escape and Revenge remained significantly associated with previous DSH, Appeal was no longer significant ($p = 0.34$), which was not surprising given the strong association between Appeal and Escape.

The Escape, Appeal, and Interruption motives remained significantly associated with suicide intent. However, multivariate results were difficult to interpret given the opposing associations observed at a univariate level.

DISCUSSION

The main underlying motives reported by self-harming patients in the present study were to escape—whether from unbearable thoughts, or an unbearable situation—and the wish to die. This finding is strikingly consistent with earlier studies in other countries that used the MPQ or variations of it (Bancroft et al., 1976; Bancroft et al., 1979; Kerk-

TABLE 4
Association Between Suicide Intent and Repeater Status and Motive Scores

	Previous DSH		High Suicide Intent	
	Odds Ratio (95% CI)	Test for trend ¹	Odds Ratio (95% CI)	Test for trend ¹
Escape ≤ 2	1.0	0.006	1.0	0.02
Escape = 3	1.61 (0.70 to 3.70)		2.26 (0.96, 5.34)	
Escape = 4	3.77 (1.46 to 9.75)		2.30 (1.23, 7.23)	
Revenge = 0	1.0	0.007		
Revenge = 1	2.94 (0.76 to 11.36)			
Revenge = 2	4.19 (1.32 to 13.24)			
Appeal = 0	1.0	0.006	1.0	<0.001
Appeal = 1	2.10 (0.89 to 4.95)		0.35 (0.15, 0.84)	
Appeal ≥ 2	3.30 (1.39 to 7.81)		0.22 (0.09, 0.50)	
Interruption ≤ 2			1.0	0.002
Interruption = 3			0.16 (0.06, 0.43)	
Interruption = 4			0.34 (0.12, 0.92)	

Note. Results are presented as odds ratio (95% confidence interval) where odds are relative to the lowest grouping in each case. There was no significant association between Revenge and SIS ($p = 0.22$) or between Intent (0.13) or Interruption ($p = 0.62$) and DSH.

¹Trend test based on a logic regression with motive score as an independent variable.

hof, 1985; Michel, Valach, & Waeber, 1994; Chopin et al., 2004; Rodham et al., 2004). This suggests that people engaging in DSH generally struggle to cope with the distress elicited by aversive mental states or difficult situations.

There were important differences in motives according to the repeater status of patients. Compared to first ever, repeaters reported significantly more motives at the time of the index DSH episode. The tendency of repeaters to repeat acts of DSH in response to a wide variety of nonspecific stresses has already been noted (Sakinofsky, 2000). In our study, repeaters were significantly more likely to report the desire to escape from an unbearable mental state or an unbearable situation. Similarly in Bancroft and colleagues' (1976) study, those with a history of previous DSH episodes more often reported motives referring to themselves, e.g., relief from a state of mind or worry about the future. Recent work has found evidence that repetition of DSH may be partly explained by a process of 'sensitization'

(Joiner & Rudd, 2000), during which the association between aversive cognitive and emotional states and the DSH episode is strengthened while the influence of specific stressful life events becomes less important with each additional episode. The present findings appear to lend support to this theory. Repeaters were also more likely to report motives of revenge against others—to make others pay and to make others feel guilty—and an appeal motive—to show someone how much they loved them, to get help from someone, to know if someone cared, or to change someone's mind.

Patients with high suicide intent in the present study were significantly more motivated to escape (from unbearable thoughts, an unbearable situation, by wanting to die, in order to make things easier for others). Those with low suicide intent were significantly more motivated to seek a temporary break from their problem (to get away for a while from an unacceptable situation, to sleep for a while, to let others know how desperate they felt, lost control of themselves), and to make

an appeal to others (to show someone how much they loved them, to get help from someone, to know if someone really cared, to persuade someone to change their mind). These motives appear to signal difficulties in interpersonal communication (rather than entrenched intrapersonal difficulties where death appears to be the only alternative) and as such may respond well to brief psychological interventions. There was a significant positive association between high scores on the Escape motive and on the Interruption and Appeal motives, yet despite this, high levels of suicide intent were associated with high scores on the Escape motive but with low scores on the Interruption and Appeal motives. The constellation of motives among those with high suicide intent may be more important than the associations between the motives themselves. As there was evidence of nonlinearity in the association between motive factors and both the level of suicide intent and the number of previous episodes of DSH, we considered the variation in motive scores by repeater status (first ever vs. repeater) and also by level of suicide intent (Low vs. High). The differences originally observed between sub-groups (repeaters vs. first ever, low intent vs. high intent) on motive scores were confirmed.

In our study, DSH patients who reported the motive "I wanted to die" had significantly higher SIS scores. Similarly, Kerkhof (1985) found a significant positive correlation between the motive factor Wish to Die and the SIS factor Wish to Die and also the SIS total score.

Consistent with findings in relation to between group differences in average scores, there were also significant associations between motives for DSH, level of suicide intent, and history of DSH. There was a significant positive association between previous DSH and scores on the Escape, Appeal, and Revenge motive factors. The risk of high suicide intent increased significantly with scores on the Escape motive factor, but fell significantly with higher scores on the Appeal and Interruption motive factors.

There was evidence of ambivalence experienced by those engaging in DSH at the

time of their act. All individuals who reported that they wanted to die always reported at least one other 'nondeath' motive.

The lack of significant gender differences in motives and suicide intent scores in the present study is quite remarkable—although this has been reported in one earlier study (Hjelmeland et al., 2002), suggesting that acts of DSH may serve a similar function for both genders or may be part of a common process. In the present study, multiple attempts were made to establish the presence of gender differences, because of our a priori assumption, based on clinical experience, that such differences were to be expected. Despite this, no significant differences were found. It may be that the numbers were not large enough in this study to find significant gender differences. While males scored higher than females on the SIS (Beck et al., 1974), the difference was not significant. This is in contrast with an earlier study where males' SIS scores were significantly higher than females' scores (Harriss et al., 2005), although the sample used in that study was considerably larger.

The factor structure of responses to the MPQ in this study is similar to those reported in previous studies. For example, Kerkhof (1985) in a study of DSH patients ($n = 120$) also found four factors including a Revenge factor, which was almost identical to the *Revenge* factor that emerged from our analysis; an *Appeal* factor which was largely similar to the Appeal factor in our analysis; and an Interruption factor and a Wish to Die factor, which when combined, were similar to the *Escape* factor in our analysis. The factor analysis of the pooled responses to the MPQ from five of the Nordic centres ($n = 776$) in the WHO/EURO Multicentre Study (Hjelmeland et al., 1998) resulted in four factors, including a *Revenge* factor, which was almost identical to the Revenge factor that emerged from our analysis; an *Escape* factor, which was also similar to the Interruption factor in the present study; a Seeking Attention factor, which was similar to the Appeal factor in our analysis; and a fourth factor called Intention to Die, which was almost identical to the *Escape* factor in our analysis. This similarity in

factor structure of responses to the MPQ across different samples suggests that motives for DSH are relatively similar in different countries and that, as a scale, the MPQ has good validity.

This study suffered from a number of limitations. The design is retrospective and therefore it is not possible to draw any conclusions on the predictive value of motives and suicide intent in relation to repeated DSH. The EPSIS I interviewed sample had substantially larger proportions with a diagnosis of depressive disorder and a history of repetition than the monitored sample. This is likely to have influenced the ranking of motives and the distribution of SIS scores of the total sample. Due to limited research staff, it was not possible to include all patients who presented to the study hospitals during the study period. Future research investigations should aim to examine the associations between motives, level of suicide intent, and repetition prospectively. This would also allow an examination of the changing nature of motives with repeated episodes, to establish if a process of sensitization is involved.

Despite these limitations, the present study findings have a number of important clinical implications. The finding that those who reported a wish to die always reported at least one other Nondeath motive can be taken as evidence of considerable ambivalence. This suggests that there may be opportunities for exploring more life-sustaining goals in early psychotherapeutic interventions with this sub-group of self-harm patients. Those reporting the motive "I wanted to die" also had significantly higher scores on the Suicide Intent Scale (SIS) underlining the importance of comprehensive clinical assessment supported by validated instruments, for

example the SIS, in the absence of an alternative risk assessment tool.

The relatively high number of motives reported on average (all but one person selected more than one motive) suggests generalized coping difficulties among those engaging in DSH. The significantly higher number of motives reported by repeaters further emphasizes that self-harming behavior in this sub-group may serve a number of functions based on a wide range of coping difficulties and is likely to be resistant to change. Routine risk assessment of DSH patients should include specific questions regarding a broad range of motives for the self-harm episode to effectively assess the extent of coping difficulties. Psychotherapeutic interventions should address self-harm patients' underlying problems across a broad range of areas. As the most commonly reported motive indicated an inability to tolerate distressing thoughts or situations (Escape motive), therapeutic approaches with DSH patients generally should include problem-solving and distress management skills to offer alternatives to avoiding or escaping difficult situations. The importance of escape motives among repeaters and among DSH patients with high suicide intent, underlines the need to incorporate questions about this specific coping difficulty in routine assessment. To reduce repetition of DSH in these high risk groups, therapeutic approaches need to introduce alternative coping mechanisms and distress management skills to broaden the coping repertoire. Among self-harm patients with low levels of suicide intent, an appeal motive was particularly important, which may mean that interventions providing interpersonal problem-solving skills training are more effective with this sub-group.

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